PRINTED VERIFICATION OF LICENSE, CERTIFICATE OR REGISTRATION ORDER FORM

INSTRUCTIONS:

- ☐ **Type or print clearly -Complete all information requested**
- ☐ **$30 credit card, check or money order (payable to SDBMOE)**
- ☐ **For PRIORITY include Stamped and addressed envelope, or Fed Ex or other overnight delivery co. account number** _____

☐ **CHECK CATEGORY:**

☐ Athletic Trainer	☐ Physician
☐ EMT – level_____	☐ Physician = Resident Certificate
☐ Dietitian/Nutritionist	☐ Physician = Locum tenens
☐ Medical Assistant	☐ Physician Assistant
☐ Occupational Therapist	☐ Physician Assistant = Locum tenens
☐ Occupational Therapy Assistant	☐ Physical Therapist
☐ Respiratory Care Practitioner	☐ Physical Therapy Assistant

List **ALL** Names: correct spelling; current & any additional names (i.e. maiden, other, and married)

- Legibly Print Name(s)_____

- **South Dakota license number : _____Date of Birth: _____**
- Active license years: ____ _____Attach any copies of old licenses or other documents
  NOTE*: If license lapsed or was inactive prior to 2003; an archive search will be conducted as expeditiously as possible; each search is unique with no way to predict timelines.

Mail Verification to (Name, City, State & Zip):_____

_____

_____

Print Contact Name_____ Title_____

Phone _____ Fax _____ Email_____

Credit Card number: _____

Credit Card Expiration Date: _____

Signature for Credit Card _____ _____Date_____

☐ Mail to completed form to: SD Board of Medical & Osteopathic Examiners
125 S. Main Ave.
Sioux Falls, SD 57104

☐ **FAX only if credit card info is included above: 605-367-7786**